Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 01/18/01?
   b. The request was received on 01/18/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
   a. TWCC-60 and Letter Requesting Dispute Resolution dated 04/23/02
   b. HCFAs
   c. EOBs
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/06/02
   b. Audit summaries/EOBs
   c. State Office of Administrative Hearings decisions on similar issues
   d. Carrier reimbursement methodology
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 04/26/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 04/26/02. The response from the insurance carrier was received in the Division on 05/07/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: letter dated 04/23/02
   "The date of service involved in this dispute was from January 18, 2001 for treatment regarding the above-referenced claimant's work-related injury. The Carrier denied payment with payment exception code "M" for all items provided in the UB-92, which were Fee Codes with a 'MAR' and treatment codes without a 'MAR."

2. Respondent: letter dated 05/06/02
"It is the Carrier's position that a) the requester failed to produce and credible evidence that its billing for the disputed procedure is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) the Carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; d) Medicare fair and reasonable reimbursement for similar or same services is below the Carrier's. Consequently, it is the Carrier's position that no further reimbursement is due the requester."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service (DOS) eligible for review is 01/18/01.

2. The provider, an ambulatory surgery center, billed a total of $13,603.69 on the DOS in dispute.

3. The carrier reimbursed a total of $1125.50* for the DOS in dispute and their EOB has the denial "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)." *Amount includes supplemental payment of $438.50 made after the dispute was filed.

4. Per the TWCC-60, the amount in dispute is $11,759.19. The difference between the total amount billed and the amount reimbursed is $12,478.19.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. The carrier has submitted their methodology and though, the entire methodology may not necessarily be concurred in by the Medical Review Division, the requirements of the referenced Rule have been met.

The provider has submitted reimbursement data. The provider has submitted several EOBs from this carrier, which indicate it has reimbursed the provider from 3% to 87% of the billed amount on other patients. These EOBs have an ICD-9 code of 724.2 (Lumbago) which is not similar to

the ICD-9 code 718.97 (Derangement Nos-Ankle) on this dispute. The billed amounts, on these EOBs, range from a low of $771.11 to a high of $14,032.86. This wide range would indicate that not all of these EOBs are for similar treatment. The billed amount of this dispute is $13,603.69. In addition, the provider has submitted a reimbursement log of other EOBs. This list shows the date of service, the amount billed, amount reimbursed, percentage of the billed amount reimbursed, and the payer of the bill. The list shows a wide range in the amount billed and in the amount of reimbursement received as a percentage. The list contains no references to the treatments/services performed and no ICD-9 codes.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The carrier has submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement and that meets the requirements of Rule 133.304. The provider has submitted EOBs from this carrier in an effort to show an inconsistent application by the carrier of its reimbursement methodology. Regardless of the carrier's methodology or inconsistent application of its methodology, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. An analysis of recent decisions of the State Office of Administrative Hearings indicate minimal weight is given to EOBs for documenting fair and reasonable reimbursement. The willingness of some carriers to provide reimbursement at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code. The EOBs provide no evidence of amounts paid on behalf of managed care patients of ASCs or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 6th day of June, 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.